



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

DEC 07 2001

CIN: A-01-01-00516

Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

Mr. Jeffrey Otten
President
Brigham and Women's Hospital
75 Francis Street
Boston, Massachusetts 02115

Dear Mr. Otten:

Enclosed are two copies of U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled *"Review of Medicare Outlier Payments at Brigham and Women's Hospital for Fiscal Year 1999."* A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act.
(see 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-01-01-00516 in all correspondence relating to this report.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

George Jacobs
Regional Administrator
Centers for Medicare and Medicaid Services – Region I
Room 2325
J.F.K. Federal Building
Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE OUTLIER
PAYMENTS AT BRIGHAM AND
WOMEN'S HOSPITAL FOR
FISCAL YEAR 1999**



JANET REHNQUIST
Inspector General

DECEMBER 2001
A-01-01-00516

Office of Inspector General

<http://www.oig.hhs.gov/oas/reports/>

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The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

Background

Under Medicare's prospective payment system, fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to program beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). An additional payment is made for atypical cases that generate extremely high costs when compared to most discharges in the same DRG; these atypical cases are referred to as outliers. In fiscal year (FY) 1999, Brigham and Women's Hospital (BWH) received, in addition to its DRG payments, \$11 million for 749 outlier claims.

Objective

The objective of our review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review focused on outlier payments to BWH during FY 1999.

Results of Review

We analyzed BWH's FY 1999 outlier claims to identify high risk claims, such as those where charges for a single revenue center code represented a significant percentage of total claim charges. Based on our analysis, we judgmentally selected 32 FY 1999 outlier claims for review. We reviewed these claims in conjunction with medical review staff from the Massachusetts peer review organization (MassPRO).

Our review found BWH billed \$237,089 in charges involving services that were not ordered by a physician, represented an inappropriate admission, were not provided/not ordered by a physician, or were duplicate billings. In addition, we identified \$525,143 in erroneous pharmacy charges or incorrectly billed lung acquisition charges. Based on the Medicare reimbursement methodology for outliers, we determined that these inappropriately billed services resulted in overpayments to BWH of \$295,671. During the course of our audit, the hospital performed a self-review of FY 2000 lung acquisition charges and initiated adjustments for incorrectly billed claims that returned an additional \$61,902 in overpayments to Medicare.

Recommendations

Given the importance of proper medical record documentation for both patient treatment and accurate reimbursement, we recommended BWH:

- Review documentation requirements with hospital staff to ensure that all services provided are appropriately documented in the medical record in accordance with standards of practice and Medicare laws and regulations, emphasizing the need to document physician orders.

- Improve its controls over the billing process to ensure that:
 - only services that are ordered by a physician and are actually performed are billed;
 - only inpatient admissions that are medically necessary and appropriate are billed.
- Strengthen its controls related to the detection and prevention of erroneous charges from the pharmacy department.
- Establish controls to ensure that lung acquisition charges, paid for on a reasonable cost basis, are billed under the appropriate revenue center code on the Medicare claim form.

With respect to the \$295,671 in overpayments identified during this review, the FI is processing adjustments to recover the \$90,240 in overpayments identified by MassPRO's review. The BWH has issued adjustments to the FI to reimburse Medicare for \$152,112 in overpayments due to erroneous pharmacy charges and \$53,319 in overpayments due to incorrectly billed lung acquisition charges.

The BWH also issued adjustments to reimburse Medicare for \$61,902 in overpayments due to incorrectly billed FY 2000 lung acquisition charges.

The draft report was issued on November 1, 2001 to BWH for comment. In response to the draft report, BWH concurred with our findings and identified steps they have taken, and plan to take to address our recommendations.

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INTRODUCTION

BACKGROUND

The Medicare program, established by the Title XVIII of the Social Security Act provides health insurance coverage to people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS). Under Medicare's prospective payment system (PPS), fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis-related group (DRG).

Section 1886(d)(5)(A) of the Social Security Act requires the Medicare program to pay an additional amount beyond the basic DRG payment for outlier cases. Outliers are those cases that have extraordinarily high costs when compared to most discharges classified in the same DRG.

Brigham and Women's Hospital (BWH), located in Boston, Massachusetts, is a world leader in patient care, medical education, and research as well as a major teaching hospital of Harvard Medical School. We found that outlier payments to BWH increased by approximately 267 percent from \$3 million in fiscal year (FY) 1997 to \$11 million in FY 1999. Part of this increase can be attributed to changes in the methodology used for calculating outlier payments at teaching and/or disproportionate share hospitals which became effective October 1, 1997 under provisions of the Balanced Budget Act of 1997. In FY 1999, BWH received, in addition to its DRG payments, \$11 million for 749 outlier claims.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether hospital outlier payments were reimbursed in accordance with Medicare laws and regulations. Our review included outlier payments made to BWH during FY 1999.

To accomplish our objective, we:

- Used CMS's National Claims History file to identify 749 outlier payments made to BWH during FY 1999.
- Analyzed BWH's FY 1999 outlier claims to identify high risk claims, such as those where charges for a single revenue center code represented a significant percentage of total claim charges. Based on our analysis, we initially selected a judgmental sample of 15 outlier claims for review.

- Utilized medical review staff from the Massachusetts peer review organization (MassPRO), to review the medical and billing records for 12 of the initial 15 sample claims. The MassPRO determined whether the care was medically necessary and appropriate, whether services were correctly billed, actually furnished to the beneficiary, and ordered by a physician. Three of the original sample claims were excluded from MassPRO review because the correction of significant billing errors found prior to the MassPRO review caused these claims to no longer qualify for an outlier payment in addition to their normal DRG payment.
- Reviewed unusual or aberrant charges on the itemized bills associated with the 15 judgmentally selected claims.
- Expanded our review as a result of our findings in the areas of pharmacy and lung acquisition charges associated with the first 15 judgmentally selected claims to include: 15 additional outlier claims judgmentally selected for review of pharmacy charges, and; 4 additional outlier claims judgmentally selected for review of lung acquisition charges.
- Reviewed a total of 32 hospital outlier claims¹.
- Discussed BWH's procedures for accumulating charges, creating inpatient bills and submitting Medicare claims with hospital personnel.
- Reviewed the fiscal intermediary's calculation of, and supporting documentation for, the inpatient cost-to-charge ratio used to calculate BWH's FY 1999 outlier payments.

We limited consideration of the internal control structure to those controls concerning the accumulation of charges, creation of inpatient bills and submission of Medicare claims because the objective of our review did not require an understanding or assessment of the complete internal control structure at the hospital.

We conducted our audit during the period of December 2000 through October 2001 at the BWH in Boston, Massachusetts, the MassPRO in Waltham, Massachusetts and the Boston Regional Office of the Office of Inspector General (OIG).

The draft report was issued to BWH on November 1, 2001. The BWH's written comments, dated November 29, 2001, are summarized on page 7 and appended in their entirety to this report (see APPENDIX).

FINDINGS AND RECOMMENDATIONS

Our review found that BWH received \$295,671 in overpayments related to its FY 1999 outlier claims. These overpayments involved billed charges for services that were not ordered by a physician, represented an inappropriate admission, were not provided/not ordered by a physician, were duplicate billings, represented erroneous pharmacy charges, or represented incorrect billing of lung acquisition

¹ Only 32 claims were actually reviewed because 2 of the claims selected for review of pharmacy charges were also reviewed for lung acquisition charges.

charges. Additionally, BWH performed a self-review of FY 2000 lung acquisition charges and initiated adjustments on 6 incorrectly billed claims that returned \$61,902 in overpayments to Medicare.

MEDICAL RECORD REVIEW

The MassPRO's review of 12 outlier claims found that \$237,089 in billed charges examined were in error due to either documentation problems or one claim that represented an inappropriate admission. As a result, under the Medicare reimbursement methodology for outliers, BWH received overpayments of \$90,240.

Documentation problems include services that:

- were not ordered by a physician;
- were not provided/not ordered by a physician; or
- were duplicate billings.

A properly documented medical record is essential to good clinical care. Medical record documentation is required to record pertinent facts, findings and observations about an individual's health history. The medical record documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his or her health care over time; and
- communication and continuity of care among physicians and other health care professionals involved in the patient's care.

Proper documentation also ensures that Medicare payments are made in accordance with laws and regulations.

Not Ordered by a Physician

The BWH submitted \$131,898 in charges where the medical records do not contain physician orders for the services billed.

42 CFR, Section 482.24(c)(2)(vi) requires that medical records document all practitioner's orders.
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The MassPRO's review found instances where BWH billed for services that were not ordered by a physician. For example:

The hospital billed for a portable chest x-ray; however, the medical records did not contain a physician's order for the x-ray.

Because BWH billed for services that were not ordered by a physician, the hospital received overpayments of \$52,815.

Inappropriate Admission

The BWH billed \$76,838 for an inappropriate inpatient admission.

The inappropriate admission involved a claim where the patient came to the hospital for day surgery. The MassPRO determined the inpatient admission was not medically necessary and appropriate because the patient did not require an acute level of care. As a result, the hospital received an overpayment of \$25,539.

Services Billed Not Provided/Ordered by a Physician

The BWH submitted \$1,135 in charges for products or services that were not provided. In addition, the hospital billed \$26,255 for products or services that were not provided and were not ordered by a physician.

The Hospital Manual, Chapter IV, Section 400 (G), requires that hospitals bill only for services provided.

42 CFR, Section 482.24(c)(2)(vi) requires that medical records document all practitioner's orders.

The MassPro's review of medical records found instances where BWH charged for services where the medical records do not support services billed. For instance:

The hospital billed for 1 unit of Levofloxacin; however, the medical records indicate this medication was withheld.

Contrary to Medicare regulations, BWH billed for services that were not provided/not ordered by a physician. As a result, BWH was overpaid \$11,482.

Duplicate Billing

The BWH billed \$963 in charges for services that were provided by the hospital but were billed more than one time.

The Hospital Manual, Chapter IV, Section 400 (G), requires that hospitals bill only for services provided.

The MassPRO's review of medical records identified instances where BWH billed for the same service more than once. For example:

The BWH billed for two therapy services on the same day. The first service was supported by

the medical records, the second service represents duplicate billing.

Because BWH billed more than once for the same services, the hospital received overpayments of \$404.

ITEMIZED BILL REVIEW

The OIG's review of the itemized bills associated with the 32 outlier claims at BWH found \$525,143 in billed charges examined involved either erroneous pharmacy charges or incorrectly billed lung acquisition charges. As a result, under the Medicare reimbursement methodology for outliers, BWH received overpayments of \$205,431.

Erroneous Pharmacy Charges

The BWH received excess outlier payments because the hospital billed for pharmacy items that were not provided. The hospital also incorrectly calculated a credit amount, resulting in an undercharge for a pharmacy item. Accordingly, the hospital billed for \$381,756 in erroneous pharmacy charges. Because BWH billed for pharmacy items that were not provided and incorrectly calculated a credit amount, the hospital received a net overpayment of \$152,112.

The Hospital Manual, Chapter IV, Section 400 (G), requires that hospitals bill only for services provided.

Clerical and/or input errors in the hospital's pharmacy department resulted in erroneous charges. Further, any erroneous charges identified and credited by the pharmacy department were not processed as adjustments to Medicare by the billing department. Examples include:

As the result of a posting error, the pharmacy department billed 4,003 units of Ceftriaxone rather than 8 units. The pharmacy department subsequently identified the posting error and initiated a \$316,219 credit for 3,995 units of the medication; however, the bill had already been submitted to Medicare for payment. Although there was a credit in the billing system for the amount of the overcharge, the billing department never corrected the Medicare bill or submitted an adjustment to the original claim. As a result, the hospital was overpaid \$132,559.

The pharmacy department incorrectly billed 2,001 units of Golytely solution for \$39,749 rather than 1 unit for \$20. This error occurred on 2 separate claims for a total overpayment of \$25,405.

Subsequent to our identification of the erroneous charges, BWH conducted its own risk based assessment of pharmacy charges on outlier claims. Between the OIG and BWH, pharmacy charges associated with 10 percent of the hospital's FY 1999 outlier claims were reviewed. The hospital reviewed a smaller sample of its FY 2000 and FY 2001 outlier claims. According to BWH, these assessments did not identify any material errors.

Lung Acquisition Charges

For the acquisition and storage costs of the organs used in transplantations, hospitals with approved transplantation centers must receive reimbursement under the reasonable cost basis; however, BWH billed \$143,387 in lung acquisition charges under an incorrect revenue center code, which caused the lung acquisition charges to be included in the calculation of the prospective payment amount.

42 CFR, Section 412.113(d) states that payment for organ acquisition charges incurred by hospitals with approved transplantation centers is made on a reasonable cost basis.

According to the Hospital Manual, Section 460, revenue center code 81X is used to identify organ acquisition charges. The FI's claims processing systems exclude organ acquisition charges billed under revenue center code 81X from the calculation of the prospective payment amount; however, BWH billed lung acquisition charges under revenue center code 89X. Consequently, the lung acquisition charges were inappropriately included in the calculation of the prospective payment amount resulting in outlier payments. As a result, the hospital received overpayments of \$53,319 for 5 claims with incorrectly billed lung acquisition charges.

The BWH also identified 6 FY 2000 lung transplant outlier claims with incorrectly billed lung acquisition charges and initiated adjustments that returned \$61,902 in overpayments to Medicare. We commend the hospital on their actions.

RECOMMENDATIONS

Given the importance of proper medical record documentation for both patient treatment and accurate reimbursement, we have recommended BWH:

- Review documentation requirements with hospital staff to ensure that all services provided are appropriately documented in the medical record in accordance with standards of practice and Medicare laws and regulations, emphasizing the need to document physician orders.
- Improve its controls over the billing process to ensure that:
 - only services that are ordered by a physician and are actually performed are billed;
 - only inpatient admissions that are medically necessary and appropriate are billed.
- Strengthen its controls related to the detection and prevention of erroneous charges from the pharmacy department.
- Establish procedures in the billing department for the recognition of credits to Medicare billing and the processing of appropriate adjustments.
- Establish controls to ensure that lung acquisition charges, paid for on a reasonable cost basis, are billed under the appropriate revenue center code on the Medicare claim form.

With respect to the \$295,671 in overpayments identified during this review, the FI is processing adjustments to recover the \$90,240 in overpayments identified by MassPRO's review. The BWH has issued adjustments to the FI to reimburse Medicare for \$152,112 in overpayments due to erroneous pharmacy charges and \$53,319 in overpayments due to incorrectly billed lung acquisition charges.

The BWH also issued adjustments to reimburse Medicare for \$61,902 in overpayments due to incorrectly billed FY 2000 lung acquisition charges.

AUDITEE COMMENTS

In response to our draft report, BWH agreed with our findings and identified steps they have taken, and plan to take to address our recommendations. The full text of the hospital's comments are included as the APPENDIX to this report.

APPENDIX



BRIGHAM AND
WOMEN'S HOSPITAL

Professional Billing Compliance
75 Francis Street
Boston, Massachusetts 02115
Tel: 617-732-7868

January 4, 2002

Mr., George Jacobs
Regional Administrator
Centers for Medicare and Medicaid Services – Region 1
Room 2325
J.F.K. Federal Building
Boston, Massachusetts 02203

Re: CIN: A-01-01-00516

Dear Mr. Jacobs,

We are in receipt of U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services report entitled "Review of Medicare Outlier Payments at Brigham and Women's Hospital '(BWH)' for Fiscal Year 1999" dated December 2001. As requested in the OIG cover letter dated December 7, 2001 we are responding to you with comments relative to their findings.

In response to the OIG's draft report we submitted a detailed response dated November 29, 2001 conveying our conclusion that their findings are substantially correct and outlining corrective actions that have been implemented based on their recommendations. I have attached a copy of that document for your files.

As explained by the OIG, their review of 32 judgmentally selected FY 1999 outlier claims identified charge errors resulting in overpayments of \$295,671 in FY 1999 and \$61,902 in FY 2000 and refunds have been processed as appropriate. A thorough reading of OIG's report will reveal that these overpayments were the result of two major factors - inadequate or missing documentation in the medical record and human error in posting to our billing and pharmacy systems. Our corrective action plans included enhanced education to the physician community, and enhanced controls in our billing systems. Most of our corrective actions were in place by the conclusion of OIG's audit. An exception was our planned publication of an article in our "Professional Staff Update" to emphasize the need for physicians to document all services in the medical record as appropriate. This article was published in the December 2001 edition and is titled "Important Notice: Test Orders and Documentation".

The BWH has found this process to be useful in our ongoing efforts to ensure compliance with Medicare program guidelines. The collaborative approach used by the OIG and the BWH in this process ensured that both parties were aware of potential issues as they emerged, ensuring appropriate clarification and discussion making in a mutually expeditious manner. As result, timely efforts by our Patients Accounts, Quality Assurance, Compliance, and Operations staffs enabled us to implement corrective actions that enhance our ability to prevent similar documentation and billing errors in the future.

If you have any questions please feel free to contact me at 617-732-7868.

Cornelius J. Walsh

A handwritten signature in cursive script, appearing to read 'Cornelius J. Walsh', written in dark ink.

Director, Professional Billing Compliance

cc: Jeffrey Otten
Roger Deshaies
Troyen Brennan, MD
Christian Presley
Michael Armstrong, OIG

Attachment



**BRIGHAM AND
WOMEN'S HOSPITAL**

Professional Billing Compliance
75 Francis Street
Boston, Massachusetts 02115
Tel: 617-732-7868

November 29, 2001

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

Re: CIN: A-01-01-00516

Dear Mr. Armstrong

On behalf of Jeffrey Otten and Brigham & Women's Hospital ("BWH"), thank you for the opportunity to review and comment on your draft report entitled "Review of Outlier Payments At Brigham and Women's Hospital For Fiscal Year 1999." The report has been reviewed in light of discussions with your office and we agree that the findings are substantially correct. The review has been useful to us and we offer the following corrective actions that BWH has implemented based on your recommendations:

1. Recommendation: "Review documentation requirements with hospital staff to ensure that all services provided are appropriately documented in the medical record in accordance with standards of practice and Medicare laws and regulations, emphasizing the need to document physicians orders."

Corrective Action(s):

- Following your review, our Professional Billing Compliance Department incorporated a document entitled "Diagnostic Tests – Physician Ordering and Documentation of Medical Necessity" into the materials covered and distributed during annual educational sessions with our Hospital employed physicians.
- We will also publish a related article in our "Professional Staff Update," a monthly publication sponsored by our Chief Medical Officer and widely distributed within the physician community at BWH.

2. Recommendation: "Improve controls over the billing process to ensure that: only services that are ordered by a physician and are actually performed are billed."

Corrective Action(s):

- Our review of claims detail leading to your recommendation indicates that there is no apparent trend of service type that lacks orders making it difficult to focus our corrective action initiatives. As a result we have taken corrective measures outlined above relative to staff education. Given that all of the claims you reviewed involved complex surgeries, we believe that verbal orders given during the surgery may not have been properly documented. We have emphasized the need to authenticate by computer key or pen, any verbal order within 24 hours of its issuance.

3. Recommendation: "Improve controls over the billing process to ensure that only inpatient admissions that are medically necessary and appropriate are billed."

Corrective Action(s):

- Since your review resulted in the denial of only one inpatient admission for reasons of medical necessity, we enlisted the help of our Compliance Department Medical Director in reviewing this case. The admission in question involved a patient with a diagnosis of malignant neoplasm of the trachea, bronchus and lung upper lobe who had undergone a thoracoscopic resection followed by a stay in the TICU. Review of the case with the attending revealed that the patient was hypoxic after the procedure and this contributed to the decision for an overnight stay. Unfortunately the hypoxia was not documented in the medical record. We have not taken extensive corrective actions around this denial as we believe our existing structure of quality assurance, and documentation/coding reviews conducted by the operations and compliance staffs is sufficient at this time.

4. Recommendation: "Strengthen its controls related to the detection and prevention of erroneous charges from the pharmacy department."

Corrective Action(s):

- The single largest contributor to your pharmacy recommendation involved billing for 2001 product units when only 1 product unit was issued. Since the review period, the pharmacy department software had been enhanced to provide an alert to the operator when the units dispersed is greater than 9. This enhancement is designed to prevent operator-input errors. The software

has also been enhanced to include an exception alert that is designed to report on charges greater than \$1000. Each of these alerts is followed up by a pharmacy staff member to ensure that charges are accurate and to prevent billing errors.

5. Recommendation: "Establish controls to ensure that lung acquisition charges, paid for on a reasonable cost basis, are billed under the appropriate revenue center code on the Medicare claim form."

Corrective Action(s):

- As a result of your identification of this issue and our subsequent review and discovery of similar occurrences in FY2000, managers of our accounts receivable and charge description master departments reviewed the mapping related to Double Lung Acquisition and Lung Acquisition. As a result of their efforts, internal mapping changes were made to ensure the proper use of revenue code 810 "Organ Acquisition" for these services.

I would also like to take this opportunity to commend your staff on their professionalism throughout this review. Their collaborative approach to the process ensured that both the OIG and BWH were aware of potential issues as they emerged, ensuring appropriate clarification and decision making in a mutually expeditious manner. As a result, we find ourselves familiar with the results and your recommendations and in the favorable position of reporting that appropriate corrective actions have been implemented to enhance our ability to prevent similar documentation and billing errors in the future.

If you have any questions please feel free to contact me at 617-732-7868.

Sincerely,



Cornelius J. Walsh

Director, Professional Billing Compliance

cc: Jeffrey Otten
Roger Deshaies
Troyen Brennan, MD
Christian Presley